Alyssa Frey, M.S., OTR/L, LLC
509 Valley St. Maplewood, NJ 07040
info@alyssafreycst.com

CHILD INTAKE FORM (Ages 2-12 years old)

General Information

Child's Name: _____

Age: _____

Date of Birth: _____

Parents' Name: _____

Phone: _____

Email: _____

Address: _____

Pediatrician: _____

Referred By: _____

Prenatal History

History of Pregnancy (medical issues/medications):

_____

_____

_____

_____

_____

Labor and Delivery

Length of pregnancy: _____ Type of Delivery: _____

Complications/Interventions: _____

_____

Weight: _____ Height: _____

Early History Condition of Newborn

Problems/Concerns: _____

Feeding: (breast/bottle/combination/ special formula/etc.): _____

Colic (yes/no): _____

Reflux (yes/no): _____

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Arching Pattern (yes/no): _____

Flatulence (yes/no): _____

Bowel Issues (yes/no): _____

Difficulty Sleeping/Settling (yes/no): _____

Developmental Milestones (indicate age)

Sat Alone: _____ Crawled: _____Walked: _____Ran: _____

General Health

Surgery/hospitalizations: _____

Past injuries:_____

Recent or current medication: _____

Allergies/sensitivities: _____

Eating (picky/appetite): _____

Eye problems: _____

Ear Infections/hearing difficulties: _____

Activity level (low, medium, high): _____

Current therapies/services: _____

_____

_____

Main goals of therapy:_____

_____

_____

Parent signature *Enter first and last name:* _____

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DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call me to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Alyssa Frey, M.S., OTR/L, LLC to use and disclose health information related to my current treatment to: *Please indicate name, relationship, and other relevant information.*

1._____

2. _____

3. _____

4. _____

5. _____

This authorization for release of information covers all past, present, and future periods.

☐ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____ Date: _____

Relationship to client (e.g self, parent, guardian, etc) _____

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CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE

I voluntarily consent to have Alyssa Frey, M.S., OTR/L, LLC, provide evaluation and/or treatment. I understand the practice of Occupational therapy and Craniosacral therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive is limited to Occupational therapy services and/or Craniosacral therapy and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

I further authorize Alyssa Frey, M.S., OTR/L, LLC to release to appropriate agencies, any information acquired during my, or the above-named, examination and treatment necessary to secure payment for services provided.

Signature: _____

Relationship to client (e.g., parent, guardian) _____

Date: _____